

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11503

CERTIFICATE OF DEATH

11508

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. STREET ADDRESS LEONARDTOWN	
76		18.1	
3. NAME OF DECEASED (Type or print) MARY		First ALBERTA	Middle BLACKSTONE
4. DATE OF DEATH AUGUST 25, 1967		Month August	Doy 25 Year 1967
5. SEX FEMALE		6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 31, 1905		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GOUGH		14. MOTHER'S MAIDEN NAME SADIE HAYDEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT LUCIOUS BLACKSTONE		Address LEONARDTOWN, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 464 X DUE TO <i>Pulmonary Embolus</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO <i>Fibrinous Phlebitis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 20, 1967 , to Aug 25, 1967 , that (I) (we) last saw the deceased alive on Aug 25, 1967 , and that death occurred at 10P M, from causes and on the date stated above.		22b. DATE SIGNED 8/27/67	
22a. SIGNATURE <i>WILLIAM D. BOYD</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS LEONARDTOWN, MARYLAND
22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M. D.		23d. LOCATION (City or Town) (County) (State) 8 HOLLYWOOD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 28, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS CEMETERY
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE AUG 31 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11509

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

11504

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be rejoined for your files.

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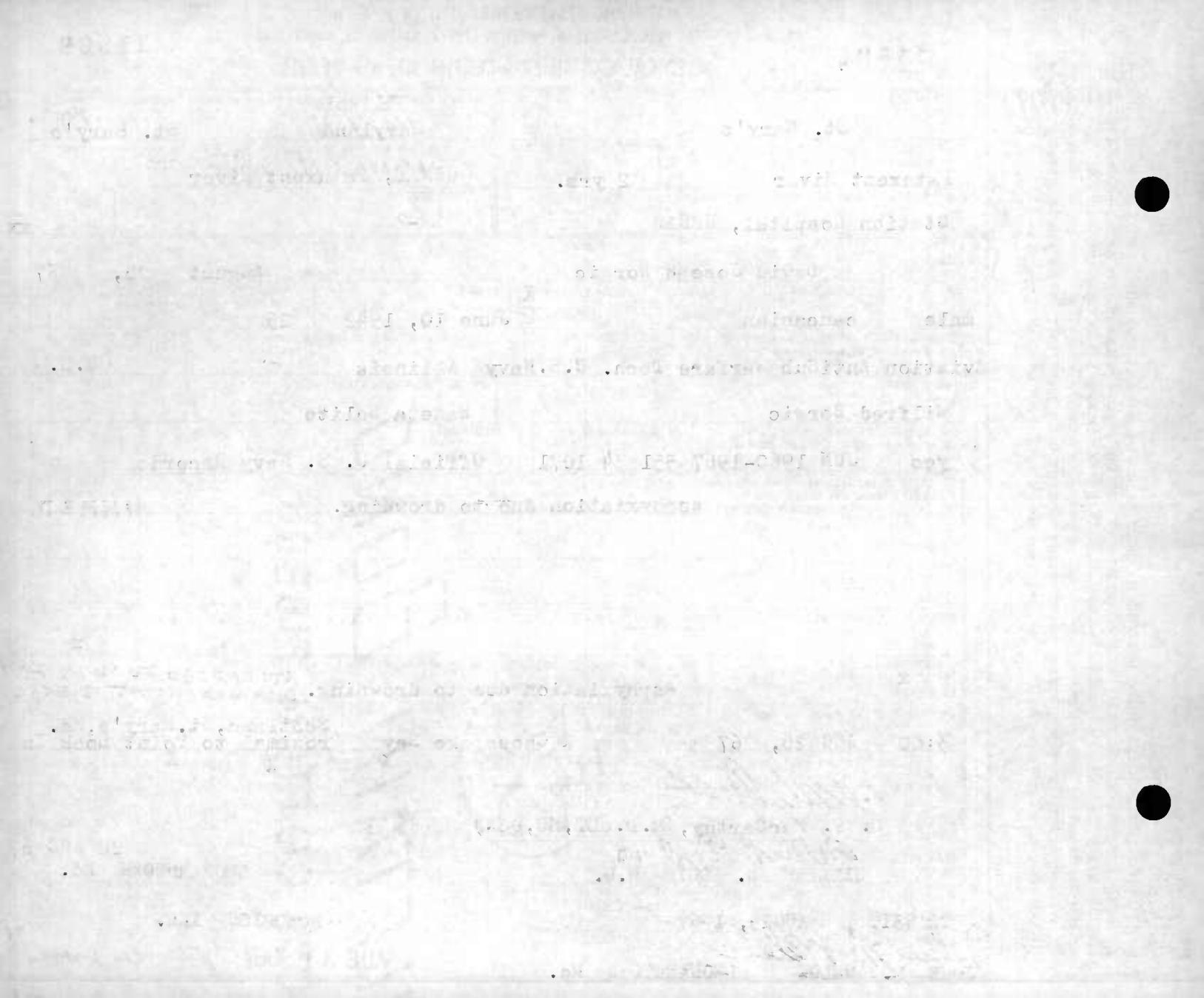
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10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE	
St. Mary's MARYLAND		Illinois	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		b. COUNTY	
c. LENGTH OF STAY IN lb 2 yrs.		Mont.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNAS		St. Mary's	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		51.3	
3. NAME OF DECEASED (Type or print)		First	Middle
David Joseph Borgic			Last
4. DATE OF DEATH		Month	Day
August 28, 1967		Year	
5. SEX		6. COLOR OR RACE	7. MARRIED
male		caucasian	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR Months Dots Hours Min.
June 10, 1942		25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviation AntiSub Warfare Tech. U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Wilfred Borgic		Waneta Bolite	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes JUN 1960-1967		16. SOCIAL SECURITY NO.	17. INFORMANT
		351 34 1071	Address Official U. S. Navy Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Asphyxiation due to drowning.	
929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH IMMED.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Asphyxiation due to drowning. ATTEMPTED TO SWIM FROM DISABLED BOAT TO SHORE	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 3:00 p.m. AUG 28, 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Chesapeake Bay
		20f. (City or town) Scotland, St. Mary's, Md.	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 28 AUG 67	
ACTUAL SIGNATURE C. F. MacCarthy, M.D. (LT, MC, USN) M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF AUG 29, 1967	23c. NAME OF CEMETERY OR CREMATORIAL NOKOMIS ILL.
24. FUNERAL DIRECTOR JOHN M. WELCH		ADDRESS LEONARDTOWN Md.	25a. REC'D BY REGISTRAR DATE AUG 31 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

11506

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11511

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
a. COUNTY ST. MARY'S MARYLAND		a. STATE MARYLAND ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PINEY POINT		c. LENGTH OF STAY IN lb LIFE		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PINEY POINT		d. STREET ADDRESS		
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CLARENCE A. BRISCOE		First CLARENCE	Middle A.	
4. DATE OF DEATH 27. 1967		Lost BRISCOE	Month AUGUST	
5. SEX MALE		6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
8. DATE OF BIRTH SEPT. 8, 1896		9. AGE (In years lost birthday) 70 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM BRISCOE		14. MOTHER'S MAIDEN NAME CAROLINE WILSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 4201		16. SOCIAL SECURITY NO. 570-01-4703		
17. INFORMANT DENICE M. DICKENS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		
		INTERVAL BETWEEN ONSET AND DEATH hours		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 8-29-67		
ACTUAL SIGNATURE <i>WILLIAM D. BOYD M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) WILLIAM D. BOYD M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 31, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ST. GEORGE CEMETERY	23d. LOCATION (City or Town) VALLEY LEE, ST. MARY'S, MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR Charles Judge
				25b. REGISTRAR'S SIGNATURE

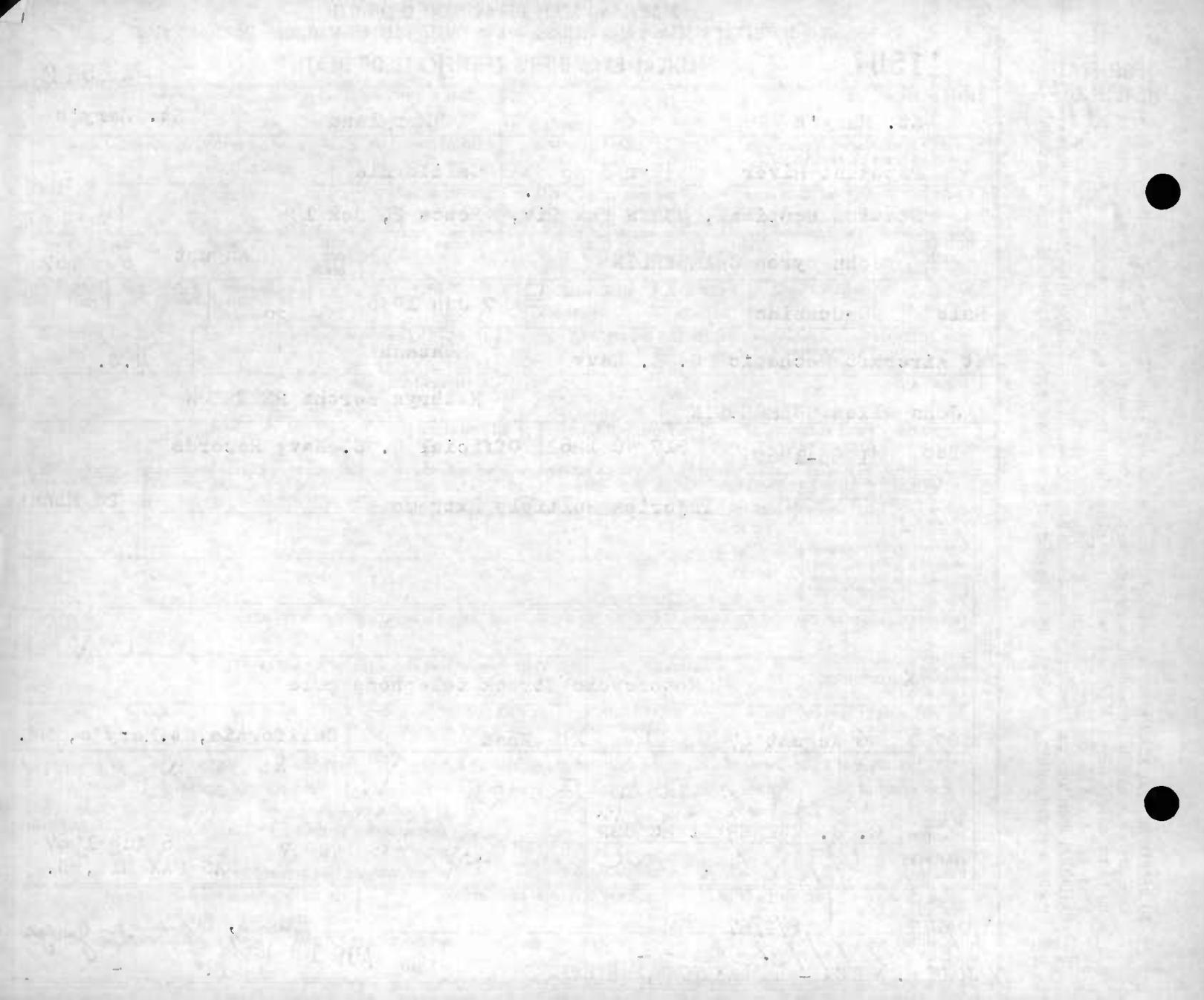
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201FOR STATE
HEALTH DEPT.1
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11507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11512

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. LENGTH OF STAY IN lb 2yr 3 mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. Station Hospital, USNAS Pax Riv,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Byron CHAMBERLIN		First	Middle
		. Last	
		4. DATE OF DEATH Month August Day 6 Year 1967	181
S. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Jan 1938
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jet Aircraft Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	11. BIRTHPLACE (State or foreign country) Montana
13. FATHER'S NAME John Allen CHAMBERLIN		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1955-1967		16. SOCIAL SECURITY NO. 517 40 1262	17. INFORMANT Address Official U. S. Navy Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries Multiple Extreme</u> 8214 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO (c) _____		N 20 MINUTE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Motorcycle Struck telephone pole	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 0750 p.m. 6 August 1967		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Road
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspectian <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Actual Signature <u>G. J. VUKMER Lt MC USN</u> Examiner's Name (Type) <u>J. J. Jukmer</u>		22. DATE SIGNED 6 Aug 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF 8/9/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND
24. FUNERAL DIRECTOR John M. Welch		25a. REC'D BY REGISTRAR AUG 10 1967	25b. REGISTRAR'S SIGNATURE F. J. J. Judge



1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11503 Item #9 Film #G392 7/1/67 11513
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

St. Mary's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

Leonardtown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

76 St. Mary's Hospital

3. NAME OF
DECEASED
(Type or print)

First MIDDLE
BABY GIRL

Last

4. DATE
OF
DEATH

Month

Day Year

Courtney

August 21 1967

5. SEX
Female

6. COLOR OR RACE
Negro

7. MARRIED
WIDOWED

NEVER MARRIED
DIVORCED

8. DATE OF BIRTH

August 21 1967

9. AGE (In years
last birthday)

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

yrs.

Months

Days

Hours

2

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

MARYLAND

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

James (Unknown) Smith

Mary Frances Courtney

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mother

Lexington Park, Maryland

INTERVAL BETWEEN
ONSET AND DEATH

776X
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

Prematurity

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?

YES

NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (the hospital) attended the deceased from 9/21/67 to 9/21/67, 1967, that (I) (we) last saw the deceased alive on 9/21/67, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE SIGNED
M.D. ATTENDING MED. STAFF
PHYS. DIRECTOR PHYS. 8/22/67

22c. PHYSICIAN'S
NAME (Type)

James P. Jarboe M.D.

Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION (City, town or county) (State)

BURIAL

8/23/67

ST. JOSEPH'S CEMETERY

MORGANZA, MD.

24. FUNERAL DIRECTOR

Robinson's

ADDRESS

Leonardtown, Md.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE

AUG 25 1967

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11509

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
ST. MARYS MARYLAND		a. STATE MARYLAND	b. COUNTY ST. MARYS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		RURAL MECHANICSVILLE	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
RT. #1		e. DATE OF DEATH AUG. 9 1967	
3. NAME OF DECEASED (Type or print) GEORGE		First M.	Middle FENWICK
4. DATE OF DEATH AUG. 9 1967		Month AUG.	Day 9
5. SEX MALE		6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH AUG. 13, 1916		9. AGE (In years last birthday) 50 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HARRY FENWICK	
14. MOTHER'S MAIDEN NAME DELIA BUTLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES WWII	
16. SOCIAL SECURITY NO.		17. INFORMANT HARRY FENWICK - SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e.) 5810		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b)		DUE TO	
DUE TO		3 yrs	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
20f. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1960, to Aug. 9, 1967, that (I) (we) last saw the deceased alive on April 27, 1967, and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. ROY GUYTHOR		22b. DATE SIGNED 8/11/67	
M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) J. ROY GUYTHOR M.D.		STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS MECHANICSVILLE, MD.
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/12/67	
23c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPHS CEMETERY		23d. LOCATION (City, town or county) (State) MORGANZA, MD.	
24. BURIAL DIRECTOR'S SIGNATURE JOHN M. WELCH - LEONARDTOWN, MD.		25a. REC'D. BY REGISTRAR 2nd REG. DATE AUG 14 1967	
ADDRESS		S. SIGNATURE J. ROY GUYTHOR JUDGE	

FOR STATE
HEALTH DEPT.

Page 3 to 5

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11515

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARYS					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL				d. STREET ADDRESS 10107 PORTLAND PL.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KARL WILHELM (WILLIAM) HEINZMAN		First	Middle	Lost	4. DATE OF DEATH AUG.	Month	Doy	Year	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 8/6/1890	9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours	Year Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER (RETIRED)			10b. KIND OF BUSINESS OR INDUSTRY BAKING		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME KARL WILHELM HEINZMAN, SR.				14. MOTHER'S MAIDEN NAME SOPHIA HAUG					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 578-09-1115		17. INFORMANT MRS. LOUISE HEINZMAN SAME AS #2		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH immed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis HTD (c) 5 yr									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Wm. D. Boyd</i>	M.D.		8/10/67 22. DATE SIGNED						
EXAMINER'S NAME (Type) WM. D. BOYD M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) LEONARDTOWN, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/14/67	23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN CEMETERY	23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.						
24. FUNERAL DIRECTOR <i>John M. Welch</i>	ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR AUG 14 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11516

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN 9 DAYS		c. LENGTH OF STAY IN 1b LEXINGTON PARK, d. STREET ADDRESS Box 232	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VERNETTE AGNES		First HOPEWELL	Middle AUGUST
3. NAME OF DECEASED (Type or print) VERNETTE AGNES		4. DATE OF DEATH 26, 1967	Month Doy Year
3. NAME OF DECEASED (Type or print) VERNETTE AGNES		5. SEX FEMALE	6. COLOR OR RACE NEGRO
7. MARRIED WIDOWED		8. DATE OF BIRTH AUGUST 27, 1926	
7. MARRIED WIDOWED		9. AGE (In years lost birthday) 40 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		11. BIRTHPLACE (County & State, or foreign country) CALIFORNIA MARYLAND	
13. FATHER'S NAME SAMUEL KANE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT JEROME R. HOPEWELL SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coagulability of blood 578X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) continuous exsanguination of lost. small amount		INTERVAL BETWEEN ONSET AND DEATH 10 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 3 fractured vertebrae	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/17 , 19 67 to 8/26 , 19 67 , that (I) (we) last saw the deceased alive on 8/26 , 19 67 , and that death occurred at 754 M., from causes and on the date stated above.			
22a. SIGNATURE Barbarich		22b. DATE SIGNED 8/29/67	
22c. PHYSICIAN'S NAME (Type) MICHAEL BARBARICH M. D.		22d. ADDRESS LEXINGTON PARK, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Aug. 29, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS HOLY FACE CEMETERY		23d. LOCATION (City or Town) (County) (State) GREAT MILLS, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DAUG 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11512

CERTIFICATE OF DEATH

11517

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY St. MARY'S							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. MARY'S CITY LIFE		c. LENGTH OF STAY IN 1b 18.1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JEANNETTE BROME		First JEANNETTE	Middle BROME	Last HOWARD	4. DATE OF DEATH AUGUST 27, 1967	Month 27	Doy 19	Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 21, 1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. MARY'S CITY, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN BROME JAMES THOMAS BROME		14. MOTHER'S MAIDEN NAME ELIZA EMALINE THOMAS							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 4221		16. SOCIAL SECURITY NO.		17. INFORMANT J. SPENCE HOWARD JR.		Address SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure		DUE TO Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221		(b) Cardio-vascular disease							
(c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) LEONARDTOWN		(County) MARYLAND (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 15, 1958 to Aug 27, 1967 , that (I) (we) last saw the deceased alive on Aug 27, 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.									
22a. SIGNATURE Charles Greenwell		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/29/67					
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG. 30, 1967		23c. NAME OF CEMETERY OR CREMATORIAL TRINITY EPISCOPAL CEMETERY		23d. LOCATION (City or Town) St. MARY'S CITY		(County) MARYLAND (State)	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			

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Fig. 1. The four main components of the model.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

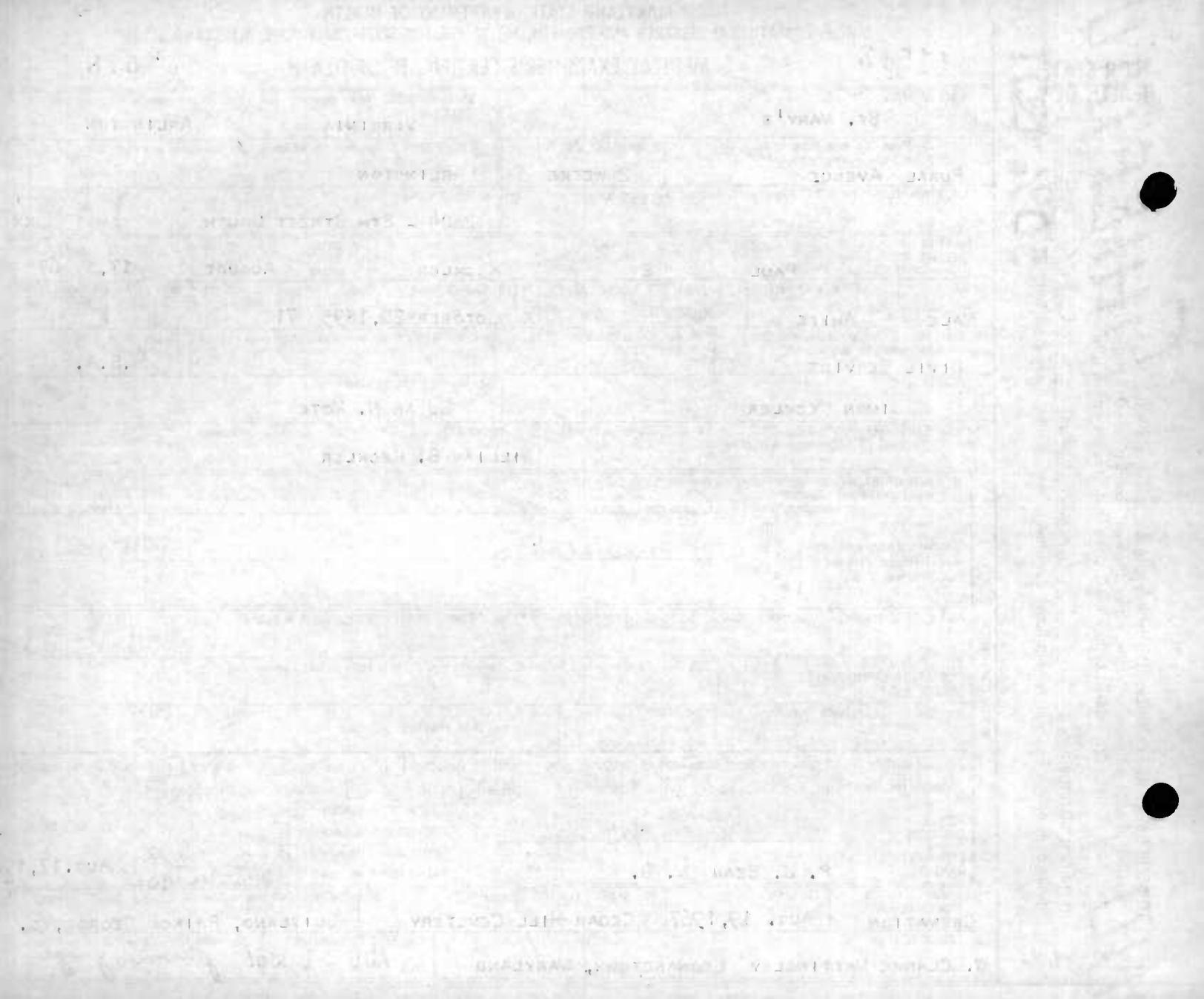
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11513

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11518

1. PLACE OF DEATH a. COUNTY St. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ARLINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL AVENUE		c. LENGTH OF STAY IN 1b 2 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 2804 - 8TH STREET SOUTH		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First PAUL	Middle E	4. DATE OF DEATH AUGUST 17, 1967	Month Year
5. SEX MALE	6. COLOR DR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH OCTOBER 20, 1895	9. AGE (In years 71 lost birthday) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME SIMON KECKLER			14. MOTHER'S MAIDEN NAME SUSAN N. NOTE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM B. KECKLER	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH 4201 <i>immediate</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Atherosclerosis</i> 5 years (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>P. J. Bean</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) P. J. BEAN M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED Address (Street, city, town, or county) <i>Princetown or Largo</i> AUG. 17, 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF AUG. 19, 1967	23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) SUITLAND, PRINCE GEORGE, MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			ADDRESS 25a. REC'D BY REGISTRAR DATE AUG 21 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

11514

CERTIFICATE OF DEATH

11519

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN 1b <i>17 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Joseph</i>	Middle <i>Ambrose</i>	Last <i>Lyon</i>
4. DATE OF DEATH <i>August 5, 1967</i>	Month	Day	Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 21, 1894</i>
9. AGE (In years last birthday) <i>72 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <i>Charles Co., Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Staunton Warren Lyon</i>	14. MOTHER'S MAIDEN NAME <i>Alice Rebecca Turner</i>	17. INFORMANT <i>Mrs. Dora Goode, Maddox, Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>217-32-1345</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221</i> <i>Cardiac Failure</i> DUE TO (b) <i>Cardio-vascular disease</i> DUE TO (c)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8/15/64</i> to <i>8/15/65</i> , 1964, that (I) (we) last saw the deceased alive on <i>8/15/65</i> 1965 and that death occurred at <i>941 M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Charles Greenwell, M.D.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Charles Greenwell, M.D.</i>		22d. ADDRESS <i>Leonardtown, Maryland.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/7/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Fort Lincoln Cemetery</i>
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>		23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Maryland</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE DATE <i>AUG 9 1967</i>	

4
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11515

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11520

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 6 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 CHURCH STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VERA MAY PONT		First VERA	Middle MAY
3. NAME OF DECEASED (Type or print) VERA MAY PONT	4. DATE OF DEATH Last AUGUST 26, 1967	Month AUGUST	Day 26
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY WEST MAITLAND AUSTRALIA	
11. BIRTHPLACE (County & State, or foreign country) N.S.W.		12. CITIZEN OF WHAT COUNTRY? AUSTRALIA	
13. FATHER'S NAME ARTHUR WILLIAM DAUNT		14. MOTHER'S MAIDEN NAME LAURA JOHNSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. JOYCE A. MATTINGLY	
17. INFORMANT LEONARDTOWN, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201		INTERVAL BETWEEN ONSET AND DEATH unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		1071.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) LEONARDTOWN, MARYLAND
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 19 67 , to Aug 14 1967 , that (I) (we) last saw the deceased alive on Aug 14 1967 , and that death occurred at 9:45 A.M. from causes and on the date stated above.			
22. SIGNATURE John F. Fenwick		22b. DATE SIGNED 8/26/67	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF AUG. 28, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS CEDAR HILL CREMATORIAL
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, MARYLAND SULTRLAND, PRINCE GEORGE MD.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE AUG 31 1967	
25c. DATE			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11516

CERTIFICATE OF DEATH

11521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		b. COUNTY ST. MARYS	
c. LENGTH OF STAY IN 1b 18-1		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) JOHN M. WELCH - LEONARDTOWN, MARYLAND		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BROTHER AMADEUS C.F.X. (REUTER)		First	Middle
4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/21/1894
9. AGE (in years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0 Deys 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE REUTER		14. MOTHER'S MAIDEN NAME ROSE BURBINK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218 54 5582	
17. INFORMANT BROTHER SCOTT * SAME AS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4201 Myocardial infarction few minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) hypertensive cardiovascular disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/10/1965 to 19..... , that (I) (we) last saw the deceased alive on 7/29/1967 , and that death occurred at M, from the causes and on the date stated above.		22b. DATE SIGNED 9/2/67	
22e. SIGNATURE S. Laurel, M.D., M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS LEONARDTOWN, MARYLAND
23e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/4/67	
23c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART NOVITIATE		23d. LOCATION (City, town or county) (State) LEONARDTOWN, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Welch		25a. REC'D BY REGISTRAR SEP 6 1967	
ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles J. Geiger	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11517

11522

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
ST. MARYS MARYLAND		a. STATE MARYLAND	b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GREAT MILLS				
3. NAME OF DECEASED (Type or print) SARAH CATHERINE SANNER		4. DATE OF DEATH AUG. 24 1967	Month Day Year			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/1889			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC				
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME WM. LEE BISCOE		14. MOTHER'S MAIDEN NAME MARY P. BISCOE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. 215 56 9870	17. INFORMANT WM. SANNER - SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO a. V. Heart block						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary sclerosis						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
Diabetes mellitus						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from June 1967 to Aug. 24, 1967, that (I) (we) last saw the deceased alive on Aug. 24, 1967, and that death occurred at 7 P.M., from the causes and on the date stated above.						
22a. SIGNATURE P.J. BEAN M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/26/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS GREAT MILLS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/27/67	23c. NAME OF CEMETERY OR CREMATORIAL TRINITY EPISCOPAL		23d. LOCATION (City, town or county) ST. MARYS CITY, MARYLAND (State)		
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. WELCH		ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a. REC'D. BY REGISTRAR DAUG 30 1967		25b. REGISTRAR'S SIGNATURE JAMES J. GAGE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11518

CERTIFICATE OF DEATH

11523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River		c. LENGTH OF STAY IN lb Newborn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Air Station Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lisa		First Marie	Middle Schaefer
S. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) St. Mary's Maryland
13. FATHER'S NAME Edward Schaefer		14. MOTHER'S MAIDEN NAME Margaret Mary Draper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Edward Schaefer
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7715		Address INTERVAL BETWEEN ONSET AND DEATH Pulmonary hemorrhage 45 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		DUE TO Hemorrhagic diathesis of newborn	
DUE TO Prematurity and hyaline disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 15 Aug 1967, to 17 Aug 1967, that (I) (we) last saw the deceased alive on 17 Aug 1967, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE James R. Abel		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 17 Aug 1967
22c. PHYSICIAN'S NAME (Type) JAMES R. ABEL		22d. ADDRESS Same as #1	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/22/67	
23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR JOHN M. WELCH		ADDRESS JOHN M. WELCH - LEONARDTOWN, MD.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE AUG 21 1967		Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

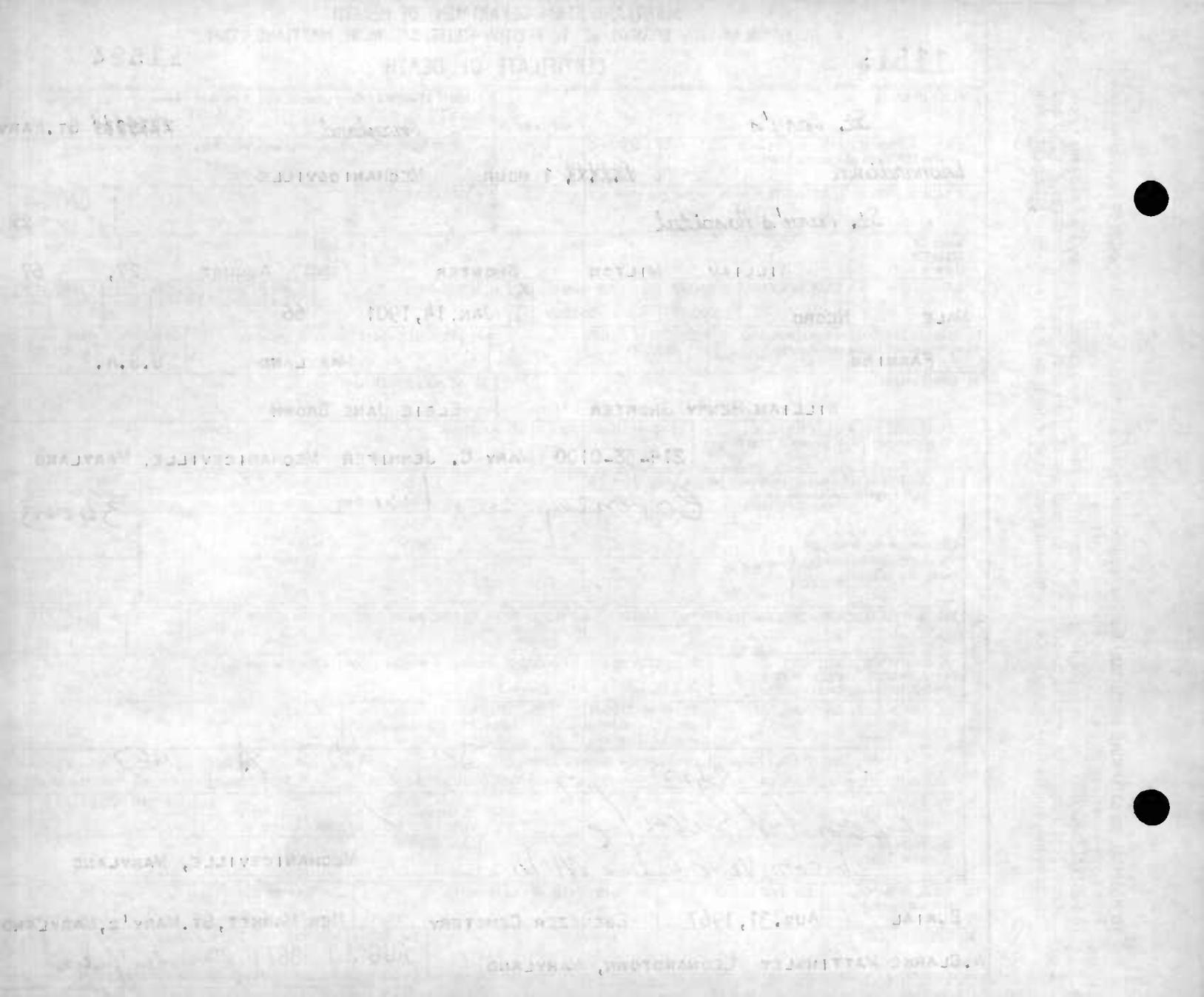
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11519

CERTIFICATE OF DEATH

11524

<p>1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u></p> <p>c. LENGTH OF STAY IN 1b <u>888888 1 HOUR</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u></p> <p>b. COUNTY <u>St. Mary's</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u></p> <p>d. STREET ADDRESS <u>181</u></p>			
<p>3. NAME OF DECEASED (Type or print) <u>WILLIAM MILTON SHORTER</u></p> <p>4. DATE OF DEATH Month <u>AUGUST</u> Day <u>27</u> Year <u>1967</u></p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>NEGRO</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>JAN, 14, 1901</u></p> <p>9. AGE (In years last birthday) <u>66</u> yrs.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>WILLIAM HENRY SHORTER</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>ELSIE JANE BROWN</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p>		<p>16. SOCIAL SECURITY NO. <u>214-58-0100</u></p>		<p>17. INFORMANT <u>MARY C. JENNIFER</u></p>		<p>Address <u>MECHANICSVILLE, MARYLAND</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____</p> <p>DUE TO _____</p> <p>(c) _____</p> <p>DUE TO _____</p>				<p>INTERVAL BETWEEN ONSET, AND DEATH <u>3 hours</u></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</p>				<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>July</u>, 19<u>55</u>, to <u>Aug</u>, 19<u>67</u> that (I) (we) last saw the deceased alive on <u>Aug 27</u>, 19<u>67</u> and that death occurred at <u>M</u>, from causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>Leon W. Berbari</u></p>				<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>			
<p>22c. PHYSICIAN'S NAME (Type) <u>Leon W. Berbari M.D.</u></p>				<p>22d. ADDRESS <u>MECHANICSVILLE, MARYLAND</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>23b. DATE THEREOF <u>Aug. 31, 1967</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>EBENEZER CEMETERY</u></p>		<p>23d. LOCATION (City or Town) (County) (State) <u>NEW MARKET, ST. MARY'S, MARYLAND</u></p>	
<p>24. FUNERAL DIRECTOR <u>W. CLARKE MATTINGLEY</u></p>				<p>25a. REC'D BY REGISTRAR DATE <u>AUG 31 1967</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>	



1
FOR STATE
HEALTH DEPT.

2
necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral
director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be
retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11520		11525	
<p>1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i></p> <p>c. LENGTH OF STAY IN 1b <i>D.O.A.</i></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i></p>		<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i></p> <p>b. COUNTY <i>St. Mary's</i></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Avenue</i> <i>Rural</i></p> <p>d. STREET ADDRESS <i>181</i></p>	
<p>3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Irvin</i> Last <i>Tippett</i></p> <p>4. DATE OF DEATH <i>August 2, 1967</i></p>		<p>5. SEX <i>Male</i></p> <p>6. COLOR OR RACE <i>White</i></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <i>Oct. 20, 1917</i></p> <p>9. AGE (in years) <input type="checkbox"/> IF UNDER 1 YEAR last birthday <i>49 yrs.</i> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i></p> <p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></p> <p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>James O. Tippett</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Gertrude Buckler</i></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>212-30-6852</i></p> <p>17. INFDRMNT <i>Mary Frances Tippett Avenue, Maryland</i></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>4201</i></p> <p>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c)</p>		<p>DUE TO <i>Coronary Insfection</i></p> <p>INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs</i></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>White</i> Not White <input type="checkbox"/> p.m. <i>19</i> at work <input type="checkbox"/> at work <input type="checkbox"/></p>		<p>20d. INJURY OCCURRED at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) <i>Bushwood</i> (County) <i>St. Mary's, Md.</i> (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>	
<p>ACTUAL SIGNATURE <i>W.D. Boyd</i></p>		<p>22. DATE SIGNED <i>8/4/67</i></p>	
<p>EXAMINER'S NAME (Type) <i>William D. Boyd M.D.</i></p>		<p>Address (Street, city, town, or county)</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>23b. DATE THEREOF <i>Aug. 5, 1967</i></p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Sacred Heart Cemetery</i></p>		<p>23d. LOCATION (City, town or county) (State) <i>Bushwood, St. Mary's, Md.</i></p>	
<p>24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i></p>		<p>25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Juges</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11521

CERTIFICATE OF DEATH

11526

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ST. Mary's Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Maggie Stahl</i>	First <i>Maggie</i>	Middle <i>Stahl</i>	Last <i>Zimmerman</i>	
4. DATE OF DEATH <i>August 13, 1967</i>	Month <i>August</i>	Day <i>13</i>	Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 8, 1909</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>57 yrs.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Penna.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Fox</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Stahl</i>	Address <i>Monroe Zimmerman Rt. 2 Box 144A Leonardtown, Maryland</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>17. INFORMANT</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiovascular collapse</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Valvular obstruction</i> (c) <i>Carcinoma of the Colon</i> INTERVAL BETWEEN ONSET AND DEATH <i>1538</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Leonardtown</i>	(County) (State) <i>Maryland</i>
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.	22a. SIGNATURE <i>A. Samad</i>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>A. Samad M. D.</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS <i>Leonardtown, Maryland</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Aug. 16, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>MENNONITE CEMETERY</i>	23d. LOCATION (City, town or county) (State) <i>Loveville, St. Mary's, Md.</i>	
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

